Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
SENTRY NEUROMONITORING

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-14-0818-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
NOVEMBER 12, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim is denied with Texas Mutual stating the claim was not filed within 90 days of the date of service. The error lies within the correct billing information as not provided to us until September. Our services were requested the patient's surgeon, Dr. Salinas, on the date of service, not the patient. The patient was in pre-op upon our arrival and already sedated upon our arrival and we rely on the facility to give us the correct billing information… We are asking that our claim be processed in good faith as the delay in filing was not ours or the patient's fault."

Amount in Dispute: $6,252.35

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "SENTRY NEUROMONITORING submitted its bill to the employer based on information provided by the hospital."

Response Submitted by: TEXAS MUTUAL INSURANCE CO

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 5, 2013	Professional Services	$6,252.35	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the procedures for medical bill submission by the health care provider.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was

processed properly.

- 29 – The time limit for filing has expired.
- 731 – Per 133.20 provider shall not submit a medical bill later than the 95th day after the date the service for services on or after 9/1/05.
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
- 724 – No additional payment after a reconsideration of services.

Issues

1. Did the requestor initially bill the employer?
2. Is the requestor entitled to reimbursement?

Findings

1. According to the requestor's position summary that initially billed the claimant's employer. In accordance with 28 Texas Administrative Code §133.20(j)(1)(C) which states, in pertinent part, "A health care provider who elects to submit medical bills to an employer waives, for the duration of the election period, the rights to medical dispute resolution as provided by Texas Labor Code §413.031.
2. The requestor has waived the right to Medical Fee Dispute Resolution; therefore, the disputed date of service cannot be reviewed.

Conclusion

For the reasons stated above, the Division finds that the requestor initially billed the employer. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 21, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.